9715

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 9 1945

Registration District No. 128

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 2000

State File No.

Registrar's No. 254

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Burge Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days. (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Webster

(c) City or town Rogersville
(If outside city or town limits, write "RURAL")

(d) Street No. Route 2
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Stockstill - Rhoda Ann.

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

4. Sex female

5. Color or race white

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife UNK.

6. (c) Age of husband or wife if alive Dec years

7. Birth date of deceased June (Month) 23 (Day) 1877 (Year)

8. AGE:

Years	Months	Days	If less than one day
67	9	9	hr. min.

9. Birthplace Spokane (City, town, or county) Mo. (State or foreign country)

10. Usual occupation H.W

11. Industry or business

FATHER
12. Name Jacob Bilyeu.
13. Birthplace UNK. (City, town, or county) Tenn. (State or foreign country)

MOTHER
14. Maiden name Sarah Elizabeth Sissel.
15. Birthplace UNK. (City, town, or county) Ark. (State or foreign country)

16. (a) Informant Arley Stockstill (Son)

(b) Address 2013 N. Newton, Spfd., Mo.

17. (a) Buried (Burial, cremation, or removal) (b) Date thereof Mar 27 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Chadwick, Mo.

18. (a) Signature of funeral director ALMA LOHMEYER FUNERAL

(b) Address SPRINGFIELD MO.

19. (a) 3-27-45 (Date received local registrar) (b) S W Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 24th year 1945 hour 1:15 minute A.M.

21. I hereby certify that I attended the deceased from 2-15-45, 19..., to 3-23, 1945 that I last saw h... alive on 3-23-, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hypostatic Pneumonia	4 days
Due to	
Due to	
Other conditions Deficiency Cyconis (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)

While at work? (e) Means of injury

23. Signature C. E. Feller (M. D. or other)

Address Springfield Mo. Date signed 3/24/45

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by .....

..... Registered Apprentice No. .....

working under my personal supervision.

Signed Lewis G Scherpf

Licensed Embalmer No. 3842

P. O. Address Springfield M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—3-45
I X43880

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 4715

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 25 X

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Rhoda Ann Stockstill
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June 23 1877 (Month) (Day) (Year)
8. AGE: Years 67 Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day 24 year 1944 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to 69	
Due to	
Other conditions (Include pregnancy within 3 months of death) General debility due to Senility	
Major findings of operations General vitamine deficiency with pellagra	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury
23. Signature C. E. Feller (M. D. or other)
Address Springfield Mo Date signed

SUPPLEMENTARY

PROFESSIONAL SUPPLEMENTARY INFORMATION REQUESTED

27877